

edge. On the left side the fracture extended obliquely across the angle, from behind the socket of the second molar tooth to just in front of the posterior part of the angle of the jaw. The lines of fracture were rugged, but there was no splintering of the bone.

“Dr. Struthers remarked that he was not aware of any case in which so much of the lower jaw, or in which the entire horizontal portion, had been removed by the surgeon without a fatal result. In one case, first one side of the jaw had been removed (by Mr. Ferguson), and subsequently the other side (by Mr. Spence), but the symphysis had been left. Also one side of the bone, with the symphysis and fore part of the other side, had been removed; but a considerable part of the remaining ramus was left, which would assist materially in keeping up the tongue. In none of the few cases in which it had been tried had the operation of removal of the *whole* lower jaw been successful. A principal danger appeared to be the falling back of the tongue over the superior glottis, causing choking. This the operation of tracheotomy might obviate. As the symphysis is the great connection of the tongue, the part to which it is fixed up by the genio-hyoid and genio-hyo-glossi muscles, the removal of this, together with both sides of the jaw, inevitably loosens the tongue, and leaves it constantly in danger of falling down, until new adhesions are acquired. But if the sides of the jaw are left, or one of the sides, the connection of the tongue thereto through the mucous membrane would assist in keeping the tongue forward. In this case, however, it is remarkable that the symphysis and both sides had been torn off, and yet, although no surgical assistance was at hand, choking had not taken place. And the case would seem to show that, after all, it is possible to remove the whole of the horizontal portion of the jaw (and it might be the entire bone) with a successful result.

“The lacerated nature of the wound had prevented hemorrhage in this case; but there must have been as much shock from this severe accident as from the ordinary operation of removing the entire jaw.

“Dr. Watson had heard of a case in which the whole lower jaw had been removed, and where the individual recovered. He remembered an American case in which there was necrosis of the whole base of the lower jaw, and where the operator removed not only the dead but the substitute bone, including the condyles, and where the patient had recovered. He had himself assisted Mr. Syme in an operation where he successfully removed one ramus and the whole of the symphysis, and where, of course, the attachments of the tongue were cut through. No doubt there was at first a tendency to retraction of the tongue, but if it were held forward for a few moments this tendency disappeared, and there was no subsequent danger of choking.”—*Edinburgh Med. Journ.*, Dec. 1861.

36. *Reunion of Severed Fingers*.—EDWARD DANIELL, Esq., records (*British Med. Journ.*, Jan. 11, 1862) the following interesting cases illustrative of the ready union of severed fingers when cut off by clean and sharp instruments:—

“A young man named Edmund Bedford, an apprentice to a wheelwright in this town, severed the end of his thumb by a sharp blow of a hatchet. He ran off immediately to me, accompanied by his fellow-apprentice. The cut was not lacerated in the least; it was a clean cut, and admirably adapted for grafting; but the end of the thumb was in the sawpit. I despatched the youth who accompanied the patient to look for it; he returned very soon with the absent portion carefully wrapped in paper, but invested in sawdust. When this was removed, I fitted the part accurately on the wound, and placed a strip of lint two-thirds down the thumb, carrying it over its loose end to the same distance on the opposite side; round this I wound a longer strip of lint, and finally secured it with strapping. To make it still safer, I covered it over with what is called a thumb-stall. At the end of ten days perfect union had taken place; and at this time the thumb is as good as ever.

“A labourer of the name of Pell, from a neighbouring village about three miles from my residence, cut off three fingers by a chaff-machine. He came hastily into the surgery, threw down his fingers on the table, and exclaimed: ‘I need not tell you what’s the matter with me, sir.’ ‘No; but I am glad you

brought your fingers with you, for I shall put them on again.' The man objected much to this, and for some time obstinately refused to submit to such 'foolish nonsense;' however, I succeeded in carrying my point, and the severed fingers were replaced on the wounds. The result was satisfactory; perfect union was established.

"About three weeks since, William Clare, of this town, publican, came to my surgery, having severed the ring finger of the left hand by a chaff-machine, immediately below the nail, cutting through the phalanx. He was followed by his son, who had discovered the finger amongst the chaff. I carefully replaced it, and treated it in the same way as the preceding cases. At the end of ten days, union was perfect. The nail sloughed off, and a new one is rapidly forming.

"I record these few cases out of many, to show what may be done by the plastic principle of adhesive inflammation even in the restoration of parts which have been separated from the living body, and usually regarded as incapable of reanimation; and also to press upon my brethren never to lose sight of the chance of trying the effects of human grafting, especially in joints like the fingers, where the measure of vital energy required for reanimation is so small.

"For my own part, I have not had a single instance of failure in a somewhat extended practice, when I have had to deal with these kind of amputations occurring in the first or second phalanx."

37. *Spontaneous Dislocation of the Femur.*—In bringing this subject before the Vienna Medical Society, Dr. DITTL adverted to the differences which existed between traumatic and spontaneous luxation. In the former, the result of great violence to a healthy subject, the *ligamentum teres* and the capsule are always torn, the head of the bone lying external to the ruptured capsule. According to the author's numerous experiments and his examination of specimens, this laceration of the capsule does not take place as a mere slit, it always becoming at the same time partially separated from its insertion in the edge of the acetabulum, forming a triangular flap, which by interposition may render reduction difficult. Spontaneous luxation, on the other hand, is always the consequence of a disease, and occurs through mere muscular action, unaccompanied by external violence. Any disease, as soft enchondroma, gelatinous cancer, etc., but most commonly inflammation, which leads to a loosening of the texture of the surrounding tissues, may give rise to the displacement. These being soaked in exsudative matters, the cartilage softens, so that a plate of it and the *ligamentum teres* may be defibrinated by means of a forcep. The capsule becoming swollen, passively yielding, and distended like a bladder. The patient usually remains upon his back, with the hip-joint bent, the head of the bone pressing upon the posterior edge of the acetabulum, in which direction it is also forced by the muscles acting through reflected contraction. For this reason the edge of the acetabulum and the corresponding portion of the head of the bone undergo diminution, and the occurrence of luxation is favoured; and, if arrest of the disease could now be obtained, the head of the bone would no longer enter the cavity completely. Contrary to what takes place in traumatic luxation, the *ligamentum teres* in this form of dislocation is not necessarily torn, and the capsule is uninjured and still retains the head within its cavity.

For the prognosis, the determination of the stage of the disease at which the luxation takes place is of great importance. At an early period, reposition is more difficult, but the result is more durable; while later, the head is easily replaced and easily resumes its abnormal position. In cases no attempt at replacement should be made. Reposition is contraindicated when the muscles have become firmly contracted, owing to the position they have retained, when abundant osteophytes have become developed and when inflammatory action is still present. Dr. Dittl thinks that direct extension should not be employed for the purpose of obtaining reposition; and, in the two cases which came under his own care, applying the hand to the knee, he bent the limb strongly forward, loosening the head of the bone from its adhesions by movements of abduction and adduction, and rotating it outwards during abduction. The after-treatment is of the highest consequence, as, if neglected, relapse may easily occur. It consists in keeping the thigh, by means of bandages, extended and rotated c